Information Form - Adult

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Preferred phone contact:

◯ Home ◯ Work ◯ Mobile

Driver's License #:

_____

Name of person, office, or other source referring you to our practice:

_____

Patient's Employer & Occupation:

_____

Emergency Contact's Name and Phone Numbers:

_____

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____
City State Zip Code

Social Security Number of insured person listed above:

_____

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____
City State Zip Code

Social Security Number of insured person listed above:

_____

Financial Guidelines

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients are ultimately responsible for all fees incurred for dental services at time of service. This office will help prepare and send claims to the insurance carrier and assist in making collections from insurance companies. This dental office cannot guarantee what the insurance benefits will be; however, we will estimate patient's portion due at time of service.

I understand that any estimate of fees for dental services will be guaranteed for 6 months from date of presentation. However, if treatment should change, a revision will be made and a new guarantee of fees will begin at the new presentation.

Our policy requires payment in full for all services rendered at the time of appointment, unless other arrangements have been approved. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency, fees, interest charges and any other expenses incurred in collecting your account.

I authorize any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient:

Response Date:

Medical History Information:

Your Primary Care Physician's name, address, & phone number:

Approximately when was your last physical exam?

What is the reason for your dental visit today?

◯ Exam ◯ Emergency ◯ Consultation

If new patient, please list prior dentist's name, address, & phone number:

When was your last visit to the dentist and what was done?

When were your last x-rays?

If you have ever had any complications following dental treatment, please explain:

Do you require Pre-medication with antibiotics before dental treatment? (if yes, write reason below)

◯ Yes ◯ No ◯ Don't Know

Reason for Pre-medication:

Have you ever taken Phen-fen or Redux (weight loss medications)?

◯ Yes ◯ No

Have you ever taken Fosamax, Aredia or other Bisphosphonates medications?

◯ Yes ◯ No

Please mark the box to indicate if any of the following apply to you presently or past history:

- ☐ Acid Reflux / GERD
- ☐ Angina
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Currently Pregnant
- ☐ Digestive Problems
- ☐ Epilepsy/Seizures
- ☐ Heart Attack
- ☐ Heart Valve Surgery
- ☐ High Cholesterol
- ☐ Jaw Problems
- ☐ Liver Disease
- ☐ Muscular Disorder
- ☐ No Epinephrine
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tobacco Use
- ☐ Alcohol / Drug Abuse
- ☐ Arthritis/Rheumatism
- ☐ Autoimmune Disorder
- ☐ Cancer/Tumor
- ☐ Depression/Anxiety
- ☐ Dizziness / Fainting
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV+ / AIDS
- ☐ Kidney Disease
- ☐ Mental Health Issues
- ☐ Neck/Back Pain
- ☐ Organ Transplant
- ☐ Pre-med Not Needed
- ☐ Shunts/Stents Placed
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Alzheimer's/Dementia
- ☐ Artificial Joints
- ☐ Bleeding Disorder
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Drug/Food Allergy
- ☐ Hearing Impaired
- ☐ Heart Murmur / MVP
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Latex Allergy
- ☐ Migraines/Headaches
- ☐ Neurological Problem
- ☐ Osteoporosis
- ☐ Premedication Needed
- ☐ Sight Impaired
- ☐ Thyroid Problems

Please list any other surgeries, drug/food allergies, or medical conditions you have or ever had that were not indicated above.

Please list any medications you are currently taking (prescription and non-prescription):

Dental History Information:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

What type of toothbrush bristles do you use?

◯ Extra-Soft ◯ Soft ◯ Medium ◯ Hard

Please indicate if you have any of the following:

☐ Red, swollen or bleeding gums.
☐ Sensitive tooth, teeth or gums.
☐ Blisters/Sores in or around mouth.
☐ Bad breath.
☐ Lost/Broken filling(s).
☐ Broken/Chipped tooth.
☐ Grinding or clenching teeth.
☐ Ringing in ears.
☐ Discomfort, clicking, popping, locking in jaw joint.
☐ Currently have dental implants, partials, or dentures.

If any of the previous concerns are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize Dr. David Hergott and/or Dr. Sara Curcio to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to Hergott Dental Associates to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

You are entitled to a copy of our "Notice of Privacy Practices". Would you like a copy?

◯ Yes ◯ No

List any individuals you would allow us to release information to:

What type of information can be shared:

◯ Dental Diagnoses and Treatment ◯ Billing/Financial Information

Signature of Patient, Parent, or Guardian:

Relationship to Patient:

Response Date: